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How do people with refractory irritable bowel syndrome perceive Hypnotherapy: qualitative study protocol

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Abstract

Introduction – irritable bowel syndrome (IBS) is a common condition which has significant impact on quality of life and has proven resistant to treatment. Hypnotherapy was recommended in National Institute of Health and Care Excellence (NICE) guidelines for the treatment of the refractory form of IBS in 2008. There is a dearth of research into the acceptability of hypnotherapy to people with IBS for their condition.

Methods – A qualitative study will be undertaken consisting of semi-structured one-to-one interviews with UK adults who have had a diagnosis of IBS for more than 12 months and continue to experience symptoms despite pharmacological intervention. Recruitment will be via large scale employers and through online IBS support and self-help groups, with snowballing from interviewees. Fifteen to twenty-five interviews will be conducted, both in person and via electronic real-time communications platforms (video calling) such as Skype. Interviews will be analysed using the framework method and will be coded twice. The first time will be inductive open coding for naturally occurring themes and the second will be theory driven deductive coding from a set of codes relating to Max Weber's antagonistic sources of power, 'Bureaucracy' and 'Charisma', which will help to identify people's conceptualisation of hypnosis.

Results - Findings will be disseminated at conferences and through peer-reviewed journals.

Discussion – The study will aid in identifying possible barriers to the use of hypnotherapy in the treatment of IBS, particularly any which relate to the perceptions of hypnosis and hypnotherapy.

1.Introduction

Irritable Bowel Syndrome (IBS) is a disorder of the gut-brain interaction [1] characterised by abdominal discomfort and a high level of variability in bowel movement frequency and form [2]. No universal prevalence figure can be agreed upon due to historical differences in diagnostic criteria and methodological issues with research [3, 4]. However, it appears to be a common condition, with studies in individual countries finding prevalence rates ranging from 1.1% [5] to 30.9% [6] and one study suggesting a potential global prevalence of 11.2% [7]. Although not life threatening, IBS is associated with substantial negative impacts on health related quality of life (HRQOL) [8] and a doubling or greater risk of suicidal behaviours when compared to healthy individuals [9]. Further, IBS is considered a difficult to treat condition [3, 10, 11] for which pharmacological approaches have limited success [10]. As a result, people with IBS often find it an expensive condition to live with, frequently expending on over the counter (OTC) remedies and complementary and alternative therapies (CAM) [12]. IBS is also expensive for the healthcare sector with one study from 2014 estimating that despite an apparently low cost to treat, IBS has a high prevalence and many costs due to related morbidity, meaning that the UK's National Health Service (NHS) may be spending £250 million a year or more because of IBS [13]. A US study identified an indirect impact cost of IBS, from such factors as lost days of work, of $791 to $7547 per person with IBS per annum [14]. The burden of IBS on people with the condition, the healthcare sector and society as a whole is therefore substantial.

Due to issues such as low responsiveness to pharmacological treatment, clinicians and academics have explored novel potential treatment strategies [15-17]. These treatments include psychological approaches, such as mindfulness [18] and CAM therapies such as probiotics, acupuncture, reflexology and Chinese herbs [19]. Amongst these novel treatments a number have been included in the UK's National Institute of Health and Care Excellence (NICE) guidelines, these include cognitive behavioural therapy (CBT), exercise, the FODMAP diet and hypnotherapy [20]. Hypnotherapy was first recommended in the NICE guidelines in 2008, as a psychological treatment approach to be considered for the treatment of refractory IBS [20] a sub category of IBS patients for whom it has demonstrable effectiveness [21, 22]. Refractory IBS is defined as IBS which has not responded to pharmacological intervention and where a continuous profile of symptoms is present twelve months or more after diagnosis [20].

Hypnotherapy is a broad therapeutic approach which may treat a condition through the use of the state of hypnosis combined with suggestion, in the form of words and metaphor [23], or by the application of adapted techniques from the various schools of psychotherapy, such as CBT [24] or psycho-dynamics [25]. There are two dominant approaches to the hypnotherapeutic treatment of IBS, these are the North Carolina Protocol [26] and the Manchester Model [27], although other variations do exist [28], collectively these are known as Gut Directed Hypnotherapy (GDH). GDH is a multiple session treatment protocol, typically taking between seven [26] and twelve sessions [29] which encourages digestive strength, regularity and calmness through imagery and suggestion [30]. Exactly how hypnotherapy effects change in IBS is unclear [31]: there is evidence which suggests that it may affect digestive motility [32], that it may be due to

cognitive alteration [33] or changes in perception of bowel distension [34]. A recent study suggested that hypnotherapy may be broadly moderating the posterior insula region of the brain, an area associated with the processing of signals from the body [35]. This could result in a decrease in the sense of urgency about bowel function as well as decreasing the discomfort and pain [36].

It is unclear how popular hypnotherapy is with people with IBS as very little research has been conducted. Figures regarding the current availability and use of hypnotherapy for IBS in the UK do not seem to exist, and their value would be debatable as it appears that provision of hypnotherapy services for IBS within the UK healthcare system is geographically variable, with a few areas benefiting from centres which treat dozens or even hundreds of patients a year, such as the Hypnosis Unit, Wythenshawe Hospital, Manchester [29, 37] or Sandwell's Nurse led Hypnotherapy service [38] but many areas appear to have no NHS services. Private hypnotherapy services appear to be widely available in the UK but there is little evidence that they are being accessed by people with IBS. One UK based study from 2008 found that 63.7% of 256 people with IBS would, in principle, consider hypnotherapy an acceptable treatment [39]. This mirrors the existing quantitative research into the public perception of hypnotherapy which suggests the majority of the public are positive towards it, although this is conditional upon the perceived qualifications of the therapist and their endorsement by the medical establishment, such as through a referral from their doctor [40]. However, this is theoretical data, how many actually use it is unclear. A US study of 419 people with IBS found that just 1.4% had actually used hypnotherapy, whereas more than double the number had been for acupuncture (3.3%), more than five times the number had seen a

psychotherapist (8.1%) and nine times the number had been for massage therapy(12.6%) [12]. This suggests that there may be some inhibition, specific to hypnotherapy, between what is theoretically acceptable and actual behaviour. What may cause this is highly speculative, one theory is that hypnosis is surrounded by myths [41] often perpetuated by images in popular media which may be intimidating, controlling or sexualised [42], in particular the hypnotist has a long history of being portrayed as possessing abilities which appear supernatural [43]. As media stereotypes can influence an individual's perceptions [44, 45] it is possible that these supernatural qualities are predominant in the public mind and may even be a barrier to hypnotherapy's use. There is evidence that hypnotherapists are conscious of the influence upon the perception of hypnotherapy which at the least stage hypnosis exerts, for example the British Society of Clinical Hypnosis (BSCH) explicitly prohibits members from using hypnosis for entertainment purposes.[46] Conversely it is possible that any perception of hypnotherapy which associates it with glamour or power may enhance its status. To address this issue Max Weber's antagonistic concepts of charismatic and bureaucratic power [47] may prove useful. Weber provides a model of power which conceives of one extreme as magical and personality driven (charisma) and the other as professional and systemised (bureaucracy), which would appear to encapsulate this tension effectively. However, lack of availability or the costs of treatment may also be at the root of the inhibition, currently we do not know because there is an almost complete absence of research into the views of people with IBS towards hypnotherapy which might help to explain and thus manage this gap. People with IBS's perception of hypnotherapy is likely to be both complex and nuanced, which makes qualitative

methods appropriate because of their ability to identify currently unknown factors whilst maintaining the human perspective [48] and they tend to produce more natural answers which are less influenced by factors such as saying the right thing [49] thus allowing the researcher to get closer to the subjective truth.

There already exists a wide body of qualitative research regarding the general subject of IBS, which covers the patient's experience of living with IBS [50-61], their encounters and engagement with the health care system [57, 62-64], their perceptions of specific treatment modalities [65-68] and general practitioners' opinions of the condition [60, 61, 69-71]. This body of research includes samples of both genders [50-56] from a variety of countries, including: Iran [50], China [58], Finland [66], Australia [60], Romania [64], Sweden and Norway [54, 56, 59, 62, 63], Canada [55, 72, 73], the United States of America [51, 52] and the UK [39, 53, 57, 61, 65, 67, 68, 70, 71]. However, some of the literature is not solely focused on IBS, and presents data which includes conditions such as chronic fatigue syndrome [69] and inflammatory bowel disease (IBD) without differentiating the findings by condition [72, 73], which limits its value. Some of the literature has a strong theoretical foundation, possibly inspired by the higher number of women with IBS than men [59], gendered perspectives appear to be predominant, such as feminist theory [63] and constructivist gender theory [59]. A major theme which arises from this work is dissatisfaction and disaffection with medical practitioners [51, 53, 54, 57-59, 61-63] although a lesser theme is present of encounters with medical practitioners in which the person with IBS felt validated [52, 61-63]. The next most substantial topic is that of personal efficacy and resilience in the face of IBS. Within this topic can be seen elements of people with IBS seeing themselves as a hero in battle

with IBS [63, 69], other psychological coping strategies [50, 53, 56, 62, 68], self-instigated behaviour changes [50, 52-54, 56, 57, 62], particularly around food and diet [52, 56-58], as well as stress management [54, 57, 58, 63, 66] and the use of CAM treatments [39, 58]. Only two pieces of work directly address the topic of hypnotherapy for IBS, one of which conducts interviews following hypnotherapy [74] and with the other hypnotherapy is only one of a number of topics addressed. This second article does however hint at a possible reason why some people with IBS may reject this potentially effective treatment, this being that hypnotherapy is perceived as more appropriate for mental rather than physical problems [39]. However, this is only one statement, much of the other data is vague, with phrases such as “I just don’t fancy it” being recorded, and ultimately the study only recorded five sentences, totalling less than forty words, related to hypnotherapy for IBS from a total study population of 256 [39]. With such a limited understanding of the perceptions of hypnotherapy by people with IBS any healthcare provider considering the provision of such a service is lacking even a rudimentary understanding of the potential patient’s perspective and knowledge of possible barriers to use of the service and what educational materials to give patients, both for their general understanding and so that they can give genuinely informed consent. This qualitative study will therefore undertake to identify the attitudes and opinions of people with IBS towards hypnotherapy as a treatment for their condition which will provide valuable information for services and practitioners who are considering the provision of hypnotherapy and thus aid in the development of a more effective service. This study will use one-to-one, face-to-face, semi-structured interviews[75] to explore the views of

people with refractory IBS about hypnotherapy and potential factors which may inhibit its usage.

2. Methods

2.1 Theory

2.1.1 Paradigm Position

The authors have adopted an interpretivist stance, this is one which views the world as the construct of individual's interactions.[76] In practice this means that the researchers accept their own influence upon the material generated and that the voice of those speaking is a true and authentic representation of their reality, even if that reality cannot be empirically validated. This has been adopted to reflect Max Weber's stance.[77]

2.1.2 Theoretical framework

Max Weber's conceptualisation of the source of authority, leadership and power [47] provides the theoretical basis for the research. Weber conceived two antagonistic concepts of authority in the world, charisma & bureaucracy [47]. A person is imbued with charismatic authority when they are perceived to be exceptional in some way, that they possess some characteristic which sets them above normal people, be this heroism, an exemplary character, or supernatural or superhuman abilities [47]. Weber's other conceptualisation of power, bureaucracy, is characterised by structure [47]. Within professions this is identified by the presence of vocational qualifications based on rational thinking within a definable system of knowledge [47]. In addition, other elements which may be present within a fully realised profession are that it is the sole occupation

of the practitioner and that it is acknowledged as a specialist role [78]. In this model hypnotherapy in the UK could be argued to be an emerging profession which is building the markers of bureaucratic authority, increasingly having externally validated qualifications and self-regulatory bodies [79]. However, as none of this is either formally or informally universal and a practitioner may have anything from a post graduate qualification to no qualification, it cannot yet be said to be an established profession [79]. In addition, it can be seen from previous quantitative research into public perceptions of hypnotherapy that most people are more open to hypnotherapy if it has an association with the medical or psychological establishment [40] which fits with Weber's concept of bureaucratic authority. Weber's theory has been used to explain and examine diverse environments [80-82] but to date we have been unable to identify its application within a health care setting. The research will attempt to establish whether the hypnotherapist is perceived as a figure of magic (charismatic), or a professional whose abilities are 'normal', learnable, regulated and scientific (bureaucratic).

2.1.3 Reflexivity and Trustworthiness

The three researchers all bring different perspectives, within the interpretivist paradigm this means that a reality will be constructed by the three researchers interacting with the participants. MK is a practicing hypnotherapist, a career which is likely to affect his perceptions and that of participants, to this end it has been decided to keep his profession undisclosed to participants unless they directly ask. KJ is a clinical academic, and SG is a medical sociologist, it is believed that the interaction of these three

professional backgrounds will serve to prevent a single perspective dominating the analysis.

2.2 Recruitment

Recruitment will be aimed directly at people with IBS, rather than through an NHS organisation, as the aim is to recruit people who are not currently engaged in seeking treatment as well as those who are. A convenience sample [83] of people with refractory IBS will be recruited using three main strategies, which in order of preference are:

1. Contacting on-line self-help and support groups.
2. Contacting local large employers
3. Paid on-line advertising

In addition, snowball sampling [84] will be used to maximise recruitment from these sources.

2.3 Sample

As a gender disparity is apparent in IBS, with an approximate ratio of two women having IBS to every man [85], an approximation of this division is aspired to. To this end gender focused versions of the recruitment strategies will be employed should natural recruitment not be sufficient. Although other demographic trends may be present in the IBS population none appear to be as pronounced as the gender division [86] and as such have not been prioritised. Recruitment will be ongoing through these strategies until an adequate sample size is achieved [87], When informed by data saturation this would be anticipated to be between 15-25 interviews [88, 89].

2.4 Interviews

2.4.1 Interview methods

Interviews will be individual, semi-structured and face-to-face. The semi-structured interview is considered to achieve an effective balance between providing topic orientation whilst allowing space for the interviewee to talk broadly [90]. The interview will either be in-person or conducted via a real-time electronic visual communications platform (video call) such as Skype [91]. Interviews via video calling have a number of theoretical advantages including financial savings [92], particularly in travel and related environmental benefits [93]. However, the primary advantage for this study was to capitalise on potential recruitment blooms, in which large numbers of potential candidates all volunteer simultaneously but are at high risk of loss of interest, a phenomenon which internet-based recruitment, with its ability to reach large numbers of people over a wide area, may generate. The choice to conduct interviews in-person or at a distance will be mutually agreed. When interviews are conducted in-person the choice of venue e.g. their home, café or local library, will be made by the interviewee. Both the decision to conduct distance interviews and to allow the interviewee to choose the location of the interview are in part motivated by the knowledge that many people with IBS become uncomfortable when they are unfamiliar with the location of lavatories in the local area [72]. When visiting people's homes or any other locations where the interviewer is likely to be vulnerable, appropriate measures to ameliorate risk will be taken [94].

2.4.2 Topic guide

A topic guide has been devised consisting of eleven primary questions, around the participant's experience of IBS, treatments for it, their perceptions of hypnosis and hypnotherapy, with both covert and overt questions that aim to capture data relating the Weberian conceptualisation of authority and bureaucracy.[47]

2.5 Participants

2.5.1 Inclusion criteria

a. Potential participants have stated that they have a medical diagnosis of IBS.

b. At least 18 years of age.

c. Fulfil, by self-report, the NICE criteria for referral for psychological intervention. This is 'people with IBS who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile'[20]. This will be assessed at first contact with the question "Would you say that you have continued to experience symptoms for 12 months or more following pharmacological treatment?"

2.5.2 Exclusion criteria

1) Previous experience of hypnotherapy for IBS. These people are excluded on the grounds that their opinions and attitudes are retrospective rather than prospective.

2) Health care professional and allied professions with a specialism in gastrointestinal problems as they are likely to have prior exposure to information and medically orientated opinions and attitudes regarding hypnotherapy for IBS.

2.6 Consent

The interviewer will seek informed consent from potential participants for the interview, its recording and transcription and subsequent use within academic publications. Recording and transcription are preferable to notes alone as they are demonstrably more accurate [95]. Issues of consent will be outlined in all written materials and for in-person interviews final consent will be obtained at the start of the face to face meeting prior to any formal topic related discussion and explained verbally before a signed consent form is completed by both interviewer and interviewee. For distance interviews consent will be first explained and sought off-record and then repeated in the recording once digital recording has been permitted by the interviewee. A consent form with return envelope will be posted to the distance interviewee. At any point up to a month after the interview the consent may be withdrawn without issue, as after the month the data will be integrated into the larger data set and not possible to disentangle.

2.7 Data analysis

Data analysis will be conducted at the first opportunity following each interview by MK, this will allow for a reflection upon the findings and a pause should it be deemed appropriate to make changes. Data will be analysed in two separate ways. The first of these will use thematic analysis [96], the researchers will conduct a process of ‘open coding’ [97], which consists of searching through the transcripts for all statements relating to IBS, hypnotherapy or any other topic which may be present and give these a code, for example ‘IBS symptoms’ or ‘CAM treatment’. Once all the material has been coded the codes will be examined to amalgamate similar codes and exclude irrelevant

data, sometimes referred to as ‘dross codes’ [97]. This will produce a smaller number of codes and the material can then be coded again under this set of reduced codes. A matrix will be created which will include the codes on one axis and the data source (individual transcripts). This will allow the researchers to examine the data both by code across data sources and to contextualise each code within the wider context of the original transcript [98]. These tables will be examined and it is anticipated that between 5-10 themes will be identified which will be explored and written up [98]. All authors will read a selection of the transcripts to determine emerging themes and these will be discussed, and a selection agreed upon. This inductive coding will allow for a broad and relatively unbiased understanding of the data and provide evidence of data saturation [89].

The second analysis will again use the framework method [98], but this time it will be a deductive approach [99], based upon Weber’s conceptualisation of sources of power. Prior to this analysis, codes relating to the theoretical basis will be determined from examination of both Weber’s theory and of previous authors’ writings about that work. These will be agreed by the authors in the same process as given above for open coding. Likely codes may include such topics as authority, science, magic, legitimacy, and professionalism. The transcripts will then be coded in line with this framework of codes, the codes will then be entered in to a matrix in the same way as for the open coded data detailed above.

NVivo software will be used for data management. Participants’ demographic data will be entered into an excel spreadsheet and imported into NVivo with the appropriate transcripts and audio files linked.

2.8 Data protection and data management

The lead author (MK) will conduct all recruitment, interviews, data entry and transcription. Data collected in the field will remain in the possession of the interviewer at all times until it can be transferred into a lockable filing cabinet. During transcription anonymization will occur by the removal of names and each interviewee will be identified with a specific designation which will be used on paper file records and for electronic file names or transcripts and audio files. Separate and stand-alone documents will be used to identify participants with their file names which will be retained in a lockable metal filing cabinet. Only the lead researcher will have access to the original data. Upon direct and written request, in line with the Data Protection Act [100], interviewees will be able to access their own data records. At the end of the study all electronic data will be transferred to password protected secure servers at the University of Birmingham.

2.9 Ethics and dissemination

The study received ethical approval under the University of Birmingham's ethics procedures (reference ENR_15-1473). The study has no serious anticipated ethical issues; however, it is considered that the interview may touch upon personal issues and as such, efforts will be made to convey the importance placed upon anonymity and confidentiality. In addition, the research will prioritise the safety, well-being and confidentiality of the participants by anticipating and avoiding potential harms, avoiding unnecessary intrusion and respecting participants' right to withdraw at any time up to a month after the interview without the need to give a reason.

3. Results

Once the findings of this study are established a suitable peer reviewed journal/s will be sought for publication. The findings will be shared at an appropriate academic conference and a summary of the findings will be distributed to participants.

4. Discussion

This study will enable further understanding of the perceptions of people with refractory IBS towards hypnotherapy as a treatment for their condition, a topic which is currently almost entirely absent of research. To the best of our knowledge never before have the Weberian concepts of charisma and bureaucracy been used to understand the perception of an emerging medical approach and as such this will help to advance application of these theoretical concepts within a new setting to inform the wider cannon of Weberian informed research.

4.1. Conclusion

The understandings gleaned will aid in the identification of possible barriers to the use of hypnotherapy by people with refractory IBS, in particular fears engendered by the perception of the hypnotherapist's source of authority, and as such will inform those considering the delivery of such a service, in particular with the design of patient educational materials.

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Conflict of interest: None.

References

[1] D.A. Drossman, W.L. Hasler, Rome IV—functional GI disorders: disorders of gut-brain interaction, Gastroenterology 150(6) (2016) 1257-1261.
[2] B.E. Lacy, K. Weiser, Gastrointestinal motility disorders: An update, Digestive Diseases 24(3-4) (2006) 228-242.
[3] X.B. Mearin, A. Balboa, E. Baró, E. Caldwell, M. Cucala, M. Díaz-Rubio, A. Fueyo, J. Ponce, M. Roset, NJ Talley, F, Irritable bowel syndrome prevalence varies enormously depending on the employed diagnostic criteria: comparison of Rome II versus previous criteria in a general population, Scandinavian journal of gastroenterology 36(11) (2001) 1155-1161.
[4] K.W. Olden, Diagnosis of irritable bowel syndrome, Gastroenterology 122(6) (2002) 1701-1714.
[5] B. Khoshkrood-Mansoori, M.A. Pourhoseingholi, A. Safaee, B. Moghimi-Dehkordi, B. Sedigh-Tonekaboni, A. Pourhoseingholi, M. Habibi, M.R. Zali, Irritable bowel syndrome: a population based study, Journal of Gastrointestinal & Liver Diseases 18(4) (2009).
[6] E. Österberg, L. Blomquist, I. Krakau, R. Weinryb, M. Åsberg, R. Hultcrantz, A population study on irritable bowel syndrome and mental health, Scandinavian journal of gastroenterology 35(3) (2000) 264-268.
[7] R.M. Lovell, A.C. Ford, Global prevalence of and risk factors for irritable bowel syndrome: a meta-analysis, Clinical Gastroenterology and Hepatology 10(7) (2012) 712-721. e4.
[8] H. El-Serag, K. Olden, D. Bjorkman, Health-related quality of life among persons with irritable bowel syndrome: a systematic review, Alimentary pharmacology & therapeutics 16(6) (2002) 1171-1185.
[9] B. Spiegel, P. Schoenfeld, B. Naliboff, Systematic review: the prevalence of suicidal behaviour in patients with chronic abdominal pain and irritable bowel syndrome, Alimentary pharmacology & therapeutics 26(2) (2007) 183-193.
[10] E. Guthrie, P.J. Whorwell, Psychotherapy and hypnotherapy in IBS, M., Camilleri, RC Spiller,(Eds.), Irritable bowel syndrome: Diagnosis and treatment (2002) 151-159.
[11] A.D. Sperber, P. Shvartzman, M. Friger, A. Fich, A comparative reappraisal of the Rome II and Rome III diagnostic criteria: are we getting closer to the 'true'prevalence of irritable bowel syndrome?, European journal of gastroenterology & hepatology 19(6) (2007) 441-447.
[12] M.A.L. Van Tilburg, O.S. Palsson, R.L. Levy, A.D. Feld, M.J. Turner, D.A. Drossman, W.E. Whitehead, Complementary and alternative medicine use and cost in functional bowel disorders: A six month prospective study in a large HMO, BMC Complementary and Alternative Medicine 8 (no pagination)(46) (2008).
[13] A. Soubieres, P. Wilson, A. Poullis, J. Wilkins, M. Rance, Burden of irritable bowel syndrome in an increasingly cost-aware National Health Service, Frontline gastroenterology (2015) flgastro-2014-100542.

[14] D. Nellesen, K. Yee, A. Chawla, B.E. Lewis, R.T. Carson, A systematic review of the economic and humanistic burden of illness in irritable bowel syndrome and chronic constipation, Journal of Managed Care Pharmacy 19(9) (2013) 755-764.
[15] P.J. Whorwell, A. Prior, E.B. Faragher, Controlled trial of hypnotherapy in the treatment of severe refractory irritable-bowel syndrome, Lancet 2(8414) (1984) 1232-1234.
[16] D.A. Drossman, W.G. Thompson, The irritable bowel syndrome: Review and a graduated multicomponent treatment approach, Annals of Internal Medicine 116(12 I) (1992) 1009-1016.
[17] H. Smart, J. Mayberry, M. Atkinson, Alternative medicine consultations and remedies in patients with the irritable bowel syndrome, Gut 27(7) (1986) 826-828.
[18] A.C. Ford, E.M.M. Quigley, B.E. Lacy, A.J. Lembo, Y.A. Saito, L.R. Schiller, E.E. Soffer, B.M.R. Spiegel, P. Moayyedi, Effect of Antidepressants and Psychological Therapies, Including Hypnotherapy, in Irritable Bowel Syndrome: Systematic Review and Meta-Analysis, American Journal of Gastroenterology 109(9) (2014) 1350-1365.
[19] Z. Hussain, E.M. Quigley, Systematic review: Complementary and alternative medicine in the irritable bowel syndrome, Alimentary Pharmacology & Therapeutics 23(4) (2006) 465-71.
[20] J. Dalrymple, I. Bullock, Diagnosis and management of irritable bowel syndrome in adults in primary care: Summary of NICE guidance, Bmj 336(7643) (2008) 556-558.
[21] A.C. Ford, E.M. Quigley, B.E. Lacy, A.J. Lembo, Y.A. Saito, L.R. Schiller, E.E. Soffer, B.M. Spiegel, P. Moayyedi, Effect of antidepressants and psychological therapies, including hypnotherapy, in irritable bowel syndrome: systematic review and meta-analysis, American Journal of Gastroenterology 109(9) (2014) 1350-65; quiz 1366.
[22] H.H. Lee, Y.Y. Choi, M.G. Choi, The efficacy of hypnotherapy in the treatment of irritable bowel syndrome: A systematic review and meta-analysis, Journal of Neurogastroenterology and Motility 20(2) (2014) 152-162.
[23] D. Hammond, Corydon-Handbook of Hypnotic Suggestions and Metaphor, WW Norton & Company, NY, 1990.
[24] I. Kirsch, G. Montgomery, G. Sapirstein, Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis, Journal of consulting and clinical psychology 63(2) (1995) 214.
[25] H. Lindner, H. Stevens, Hypnotherapy and psychodynamics in the syndrome of Gilles de la Tourette, The International Journal of Clinical and Experimental Hypnosis 15(4) (1967) 151-155.
[26] O.S. Palsson, Standardized hypnosis treatment for irritable bowel syndrome: the North Carolina protocol, International Journal of Clinical & Experimental Hypnosis 54(1) (2006) 51-64.
[27] P.J. Whorwell, Effective management of irritable bowel syndrome - The Manchester model, International Journal of Clinical and Experimental Hypnosis 54(1) (2006) 21-26.
[28] A.M. Vlieger, C. Menko-Frankenhuis, S.C.S. Wolfkamp, E. Tromp, M.A. Benninga, Hypnotherapy for children with functional abdominal pain or irritable bowel syndrome: A randomized controlled trial, Gastroenterology 133(5) (2007) 1430-1436.
[29] W.M. Gonsalkorale, L.A. Houghton, P.J. Whorwell, Hypnotherapy in irritable bowel syndrome: a large-scale audit of a clinical service with examination of factors influencing responsiveness, American Journal of Gastroenterology 97(4) (2002) 954-61.
[30] W.M. Gonsalkorale, Gut-directed hypnotherapy: the Manchester approach for treatment of irritable bowel syndrome, International Journal of Clinical & Experimental Hypnosis 54(1) (2006) 27-50.
[31] G. Tan, D.C. Hammond, G. Joseph, Hypnosis and irritable bowel syndrome: a review of efficacy and mechanism of action, American Journal of Clinical Hypnosis 47(3) (2005) 161-78.
[32] A.M. Vlieger, M.M. van den Berg, C. Menko-Frankenhuis, M.E. Bongers, E. Tromp, M.A. Benninga, No change in rectal sensitivity after gut-directed hypnotherapy in children with functional abdominal pain or irritable bowel syndrome, American Journal of Gastroenterology 105(1) (2010) 213-8.

[33] W.M. Gonsalkorale, B.B. Toner, P.J. Whorwell, Cognitive change in patients undergoing hypnotherapy for irritable bowel syndrome, Journal of Psychosomatic Research 56(3) (2004) 271-278.
[34] L. Vase, M.E. Robinson, G.N. Verne, D.D. Price, The contributions of suggestion, desire, and expectation to placebo effects in irritable bowel syndrome patients: An empirical investigation, Pain 105(1-2) (2003) 17-25.
[35] M.B. Lowen, E.A. Mayer, M. Sjoberg, K. Tillisch, B. Naliboff, J. Labus, P. Lundberg, M. Strom, M. Engstrom, S.A. Walter, Effect of hypnotherapy and educational intervention on brain response to visceral stimulus in the irritable bowel syndrome, Alimentary Pharmacology & Therapeutics 37(12) (2013) 1184-97.
[36] B. Spiegel, R. Bolus, L.A. Harris, S. Lucak, W. Chey, G. Sayuk, E. Esrailian, A. Lembo, H. Karsan, K. Tillisch, Characterizing abdominal pain in IBS: guidance for study inclusion criteria, outcome measurement and clinical practice, Alimentary pharmacology & therapeutics 32(9) (2010) 1192-1202.
[37] V. Miller, H.R. Carruthers, J. Morris, S.S. Hasan, S. Archbold, P.J. Whorwell, Hypnotherapy for irritable bowel syndrome: an audit of one thousand adult patients, Alimentary Pharmacology & Therapeutics 41(9) (2015) 844-855.
[38] H. Bremner, Designing and delivering a hypnotherapy service for irritable bowel syndrome in primary care, Frontline Gastroenterology 3(3) (2012) 210-215.
[39] L.R. Harris, L. Roberts, Treatments for irritable bowel syndrome: Patients' attitudes and acceptability, BMC Complementary and Alternative Medicine 8 (no pagination)(65) (2008).
[40] M. Krouwel, K. Jolly, S. Greenfield, What the public think about hypnosis and hypnotherapy: A narrative review of literature covering opinions and attitudes of the general public 1996-2016, Complementary Therapies in Medicine (2017).
[41] J. Meyerson, The myth of hypnosis: The need for remythification, International Journal of Clinical and Experimental Hypnosis 62(3) (2014) 378-393.
[42] D. Barrett, Hypnosis in film and television, American journal of clinical hypnosis 49(1) (2006) 13-30.
[43] D. Barrett, Hypnosis in popular media, Hypnosis and hypnotherapy 1 (2010) 77-96.
[44] D. Mastro, Why the media's role in issues of race and ethnicity should be in the spotlight, Journal of Social Issues 71(1) (2015) 1-16.
[45] R. Tukachinsky, D. Mastro, M. Yarchi, Documenting portrayals of race/ethnicity on primetime television over a 20-year span and their association with national-level racial/ethnic attitudes, Journal of Social Issues 71(1) (2015) 17-38.
[46] T. Connelly, BSCH Code of Conduct 2018. https://www.bsch.org.uk/comduct.html. (Accessed 18.12.18 2018).
[47] M. Weber, Economy and society: An outline of interpretive sociology, Univ of California Press1978.
[48] M.J. Crawford, T. Weaver, D. Rutter, T. Sensky, P. Tyrer, Evaluating new treatments in psychiatry: the potential value of combining qualitative and quantitative research methods, International Review of Psychiatry 14(1) (2002) 6-11.
[49] N. Black, Why we need qualitative research, Journal of epidemiology and community health 48(5) (1994) 425.
[50] Z. Mohebbi, F. Sharif, H. Peyrovi, M. Rakhshan, M.A. Naini, L. Zarshenas, Self-Perception of Iranian Patients during their life with Irritable Bowel Syndrome: A Qualitative Study, Electronic physician 9(12) (2017).
[51] S. Bertram, M. Kurland, E. Lydick, G.R.I. LOCKE, B.P. Yawn, The patient's perspective of irritable bowel syndrome, Journal of Family Practice 50(6) (2001) 521-521.
[52] D.A. Drossman, L. Chang, S. Schneck, C. Blackman, W.F. Norton, N.J. Norton, A focus group assessment of patient perspectives on irritable bowel syndrome and illness severity, Digestive Diseases and Sciences 54(7) (2009) 1532-1541.

[53] R. Farndale, L. Roberts, Long-term impact of irritable bowel syndrome: a qualitative study, Primary Health Care Research & Development 12(1) (2011) 52-67.
[54] C. Håkanson, E. Sahlberg-Blom, H. Nyhlin, B.M. Ternestedt, Struggling with an unfamiliar and unreliable body: the experience of irritable bowel syndrome, Journal of Nursing and Healthcare of chronic illness 1(1) (2009) 29-38.
[55] L.M. Meadows, S. Lackner, M. Belic, Irritable bowel syndrome: An exploration of the patient perspective, Clinical nursing research 6(2) (1997) 156-170.
[56] M. Rønnevig, P.O. Vandvik, I. Bergbom, Patients' experiences of living with irritable bowel syndrome, Journal of advanced nursing 65(8) (2009) 1676-1685.
[57] R.E. Casiday, A. Hungin, C.S. Cornford, N.J. de Wit, M.T. Blell, Patients' explanatory models for irritable bowel syndrome: symptoms and treatment more important than explaining aetiology, Family practice 26(1) (2008) 40-47.
[58] Z.-Y.J. Lu, W.-L. Chen, H.-C. Chen, M. Ou, Irritable bowel syndrome: The bodily experiences of Taiwanese women, Journal of Nursing Research 17(1) (2009) 42-51.
[59] I. Björkman, L. Dellenborg, G. Ringström, M. Simrén, E.J. Ung, The gendered impact of Irritable Bowel Syndrome: a qualitative study of patients' experiences, Journal of Advanced Nursing 70(6) (2014) 1334-1343.
[60] K. Crocker, A. Chur-Hansen, J. Andrews, Interpersonal relationships for patients with irritable bowel syndrome: a qualitative study of GPs' perceptions, Australian family physician 42(11) (2013) 805.
[61] M. Dixon-Woods, S. Critchley, Medical and lay views of irritable bowel syndrome, Family Practice 17(2) (2000) 108-113.
[62] C. Håkanson, E. Sahlberg-Blom, B.-M. Ternestedt, Being in the patient position: Experiences of health care among people with irritable bowel syndrome, Qualitative Health Research 20(8) (2010) 1116-1127.
[63] I. Björkman, M. Simrén, G. Ringström, E. Jakobsson Ung, Patients' experiences of healthcare encounters in severe irritable bowel syndrome: an analysis based on narrative and feminist theory, Journal of clinical nursing 25(19-20) (2016) 2967-2978.
[64] T.-S. Rotaru, L. OPREA, How Doctor-Patient Mutual Trust Is Built in the Context of Irritable Bowel Syndrome: A Qualitative Study, Revista de Cercetare si Interventie Sociala 55 (2016) 185.
[65] A. Soundy, R.T. Lee, T. Kingstone, S. Singh, P.R. Shah, L. Roberts, Experiences of healing therapy in patients with irritable bowel syndrome and inflammatory bowel disease, BMC complementary and alternative medicine 15(1) (2015) 106.
[66] C. Kortet, Patient Counselling about Stress Associated with Irritable Bowel Syndrome:-A Qualitative Study Based on Patient Experiences, (2016).
[67] S. Tonkin-Crine, F.L. Bishop, M. Ellis, R. Moss-Morris, H. Everitt, Exploring patients' views of a cognitive behavioral therapy-based website for the self-management of irritable bowel syndrome symptoms, Journal of medical Internet research 15(9) (2013).
[68] A. Sibelli, T. Chalder, H. Everitt, P. Workman, F.L. Bishop, R. Moss-Morris, The role of high expectations of self and social desirability in emotional processing in individuals with irritable bowel syndrome: A qualitative study, British journal of health psychology 22(4) (2017) 737-762.
[69] R. Raine, S. Carter, T. Sensky, N. Black, General practitioners' perceptions of chronic fatigue syndrome and beliefs about its management, compared with irritable bowel syndrome: qualitative study, Bmj 328(7452) (2004) 1354-1357.
[70] E.F. Harkness, V. Harrington, S. Hinder, S.J. O'Brien, D.G. Thompson, P. Beech, C.A. Chew-Graham, GP perspectives of irritable bowel syndrome–an accepted illness, but management deviates from guidelines: a qualitative study, BMC family practice 14(1) (2013) 92.
[71] R.E. Casiday, A. Hungin, C.S. Cornford, N.J. de Wit, M.T. Blell, GPs' explanatory models for irritable bowel syndrome: a mismatch with patient models?, Family practice 26(1) (2008) 34-39.

[72] M.A. Schneider, P.C. Fletcher, 'I feel as if my IBS is keeping me hostage!'Exploring the negative impact of irritable bowel syndrome (IBS) and inflammatory bowel disease (IBD) upon university-aged women, International journal of nursing practice 14(2) (2008) 135-148.
[73] M.A. Schneider, A. Jamieson, P.C. Fletcher, 'One sip won't do any harm...': Temptation among women with inflammatory bowel disease/irritable bowel syndrome to engage in negative dietary behaviours, despite the consequences to their health, International journal of nursing practice 15(2) (2009) 80-90.
[74] A.-s. Donnet, S. Hasan, V. Miller, P. Whorwell, PWE-128 Hypnotherapy for irritable bowel syndrome: the patient's perception, Gut 67(Suppl 1) (2018) A211-A212.
[75] C. Wilson, Interview techniques for UX practitioners: A user-centered design method, Newnes2013.
[76] A. Dammak, Research paradigms: Methodologies and compatible methods, Veritas 6(2) (2015) 1-5.
[77] M. Crotty, The foundations of social research: Meaning and perspective in the research process, Sage1998.
[78] G. Ritzer, Professionalization, bureaucratization and rationalization: The views of Max Weber, Social Forces 53(4) (1975) 627-634.
[79] K. Beaven-Marks, Influence or ignorance: an analysis of the influence of the hypnotherapy national occupational standards on hypnosis and hypnotherapy teaching and learning, and professionalism in the UK, University of Greenwich, 2013.
[80] H. Constas, Max Weber's two conceptions of Bureaucracy, American Journal of Sociology 63(4) (1958) 400-409.
[81] M.R. Lepsius, Charismatic leadership: Max Weber's model and its applicability to the rule of Hitler, Changing conceptions of leadership, Springer1986, pp. 53-66.
[82] R. Pillai, J.R. Meindl, Context and charisma: A" meso" level examination of the relationship of organic structure, collectivism, and crisis to charismatic leadership, Journal of Management 24(5) (1998) 643-671.
[83] I. Etikan, S.A. Musa, R.S. Alkassim, Comparison of convenience sampling and purposive sampling, American Journal of Theoretical and Applied Statistics 5(1) (2016) 1-4.
[84] R. Atkinson, J. Flint, Accessing hidden and hard-to-reach populations: Snowball research strategies, Social research update 33(1) (2001) 1-4.
[85] C. Hookway, S. Buckner, P. Crosland, D. Longson, Irritable bowel syndrome in adults in primary care: summary of updated NICE guidance, BMJ: British Medical Journal (Online) 350 (2015).
[86] S. Wilson, L. Roberts, A. Roalfe, P. Bridge, S. Singh, Prevalence of irritable bowel syndrome: a community survey, Br J Gen Pract 54(504) (2004) 495-502.
[87] M. Sandelowski, Sample size in qualitative research, Research in nursing & health 18(2) (1995) 179-183.
[88] G. Guest, A. Bunce, L. Johnson, How many interviews are enough? An experiment with data saturation and variability, Field methods 18(1) (2006) 59-82.
[89] M. Mason, Sample size and saturation in PhD studies using qualitative interviews, Forum qualitative Sozialforschung/Forum: qualitative social research, 2010.
[90] F. Fylan, Semi-structured interviewing, A handbook of research methods for clinical and health psychology (2005) 65-78.
[91] S. Seitz, Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: A research note, Qualitative Research 16(2) (2016) 229-235.
[92] L. Edje, C. Miller, J. Kiefer, D. Oram, Using Skype as an alternative for residency selection interviews, Journal of graduate medical education 5(3) (2013) 503-505.
[93] P. Hanna, Using internet technologies (such as Skype) as a research medium: A research note, Qualitative Research 12(2) (2012) 239-242.

[94] W. Brennan, Safer lone working: assessing the risk to health professionals, British Journal of Nursing 19(22) (2010) 1428-1430.
[95] L.S. Whiting, Semi-structured interviews: guidance for novice researchers, Nursing Standard (through 2013) 22(23) (2008) 35.
[96] V. Braun, V. Clarke, Using thematic analysis in psychology, Qualitative research in psychology 3(2) (2006) 77-101.
[97] P. Burnard, A method of analysing interview transcripts in qualitative research, Nurse education today 11(6) (1991) 461-466.
[98] N.K. Gale, G. Heath, E. Cameron, S. Rashid, S. Redwood, Using the framework method for the analysis of qualitative data in multi-disciplinary health research, BMC medical research methodology 13(1) (2013) 117.
[99] M. Fan, A. Petrosoniak, S. Pinkney, C. Hicks, K. White, A.P.S.S. Almeida, D. Campbell, M. McGowan, A. Gray, P. Trbovich, Study protocol for a framework analysis using video review to identify latent safety threats: trauma resuscitation using in situ simulation team training (TRUST), BMJ open 6(11) (2016) e013683.
[100] B. Parliament, Data protection act of 1998, 1998.